CareSTL Health

☐ CareSTL Health - Headquarters
5471 Dr. Martin Luther King Drive
Saint Louis, Missouri 63112
Office: 314.367.5820 Fax: 314.367.7010

☐ CareSTL Health
5541 Riverview Boulevard
Saint Louis, Missouri 63120
Office: 314.389.4566 Fax: 314.389.5514

☐ CareSTL Health
4500 Pope Avenue
Saint Louis, Missouri 63115
Office: 314.385.3990 Fax: 314.389.2464

School-Based Health Centers
☐ Hazelwood School District
☐ Jennings School District
☐ Ritenour School District
☐ Riverview Gardens School District

☐ CareSTL Health
2425 Whittier Street
Saint Louis, Missouri 63113
Office: 314.371.3100 Fax: 314.289.8718

For more information visit...
www.carestlhealth.org

COVID-19 Required Registration Information

SSN: _____

Name: _____

DOB:_____ Gender: _____Race: _____Ethnicity: _____

Street Address: _____

State:_____City:_____Zip Code: _____

Telephone #:_____Email: _____

Health Insurance

Subscriber: Self_____Spouse_____Dependent Child__X__(age 16-26)

Dependent Child Guardian Name: _____

Dependent Child Guardian SSN: _____

Name of Insurance Plan:_____

Group #:_____Member ID: _____

COVID-19 Screening *(refer to screening form)*

Fever:	_____YES	_____NO
Cough:	_____YES	_____NO
How long? _____		
Shortness of Breath	_____YES	_____NO
Diarrhea	_____YES	_____NO
Vomiting	_____	_____NO
Loss sense of taste	_____YES	_____NO
Loss sense of smell	_____YES	_____NO
Loss of appetite	_____YES	_____NO

Contact with person with known COVID-19: ___YES __NO

Is this a re-test? _____ YES _____ NO

_____

Parent's Signature

*****Confirm verbal consent to treat with patient*****

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☐ 5541 Riverview Boulevard
Saint Louis, Missouri 63120
Office: 314.389.4566 Fax: 314.389.5514

☐ School Based Health Center
Jennings School District
7047 Emma Avenue, Jennings, MO 63136
Office: 314.653.8135 Fax: 314.367.7010

For more information visit...
CareSTLHealth.org

Authorization for Release of Information

Patient Name	Patient Address
Date of Birth	
Social Security Number	

I hereby authorize the use and disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as protected by law. This authorization is valid for a 90 day period from the date it is signed or sooner if so specified by me. I understand that a photocopy or fax of this authorization is as valid as the original. Once this information has been released pursuant to this authorization; it may no longer be protected by federal and state law(s) regulations and may no longer be deemed confidential. This authorization may include disclosure of information relating to Alcohol and Drug Abuse, Mental Health Treatment, and Confidential AIDS/HIV Related Information. I may revoke this authorization at any time, except where information has already been released in reliance of my authorization, provided that my revocation is in writing.

Name and address of health provider or entity to release this information: CareSTL Health 5471 Dr. Martin Luther King St. Louis, MO 63112
Name and address of person(s) or category to whom this information will be sent: Chris Muskopf, Athletic Director St. Louis University High 4970 Oakland Ave, St. Louis, MO 63110

Specific Information to be Released:

☐ Medical Records from (insert date) _____ to (insert date) _____

☐ Entire Medical Record including, including patient histories, office notes, test results, Radiology studies, referrals, consults alcohol/drug treatment, mental health information, and AIDS/HIV-related information

☐ Pharmacy Records from (insert date) _____ to (insert date) _____

☐ Other

COVID-19 Test Results from October 5th , 2020 until October 5th, 2021

Signature of Patient or Legal Representative Date

Signature of Witness Date